APCD Analytic Workgroup:

How should Patient Attribution Methodologies inform approaches to improving data quality?

December 20, 2011

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Introductions

- Betty Harney (Director of Data Enhancement and Standardization)
- Kathy Hines (Director of Data Compliance and Support)
- Marc Prettenhofer (Project Manager – Senior Business Analyst)
- Paul Smith (APCD Liaison)
- Young Joo (Director of Data Strategies)
- Adam Tapply (Intern)

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Objectives for today's meeting

- Provide an overview of patient attribution methodologies
- Review experiences applying patient attribution methodologies for quality measurement and public reporting
- Discuss approaches to improving data quality using models of patient attribution methodologies
- Address questions from workgroup participants

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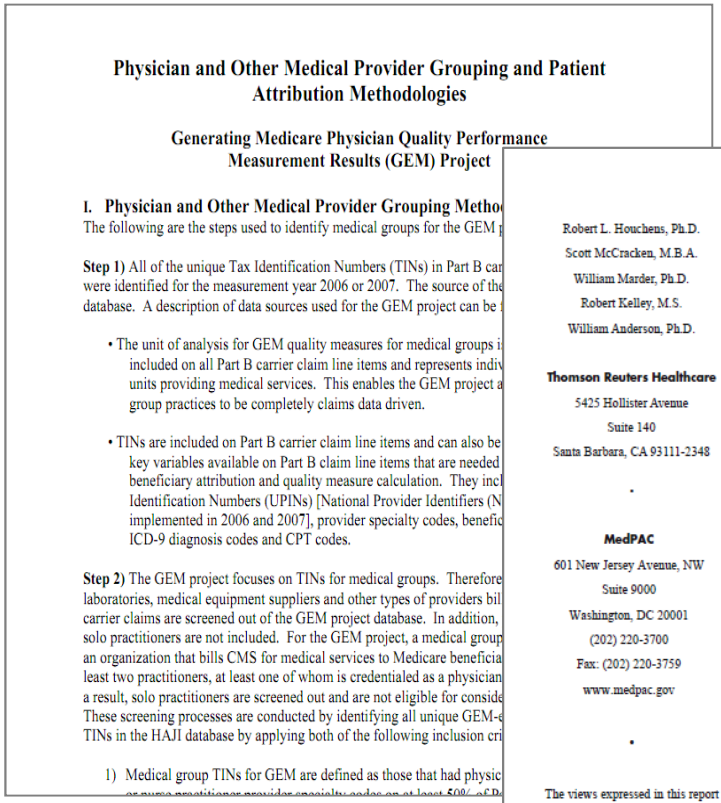
Patient attribution methodologies contribute to key health care reform initiatives



Physician and Other Medical Provider Grouping and Patient Attribution Methodologies

Generating Medicare Physician Quality Performance Measurement Results (GEM) Project

I. Physician and Other Medical Provider Grouping Metho

The following are the steps used to identify medical groups for the GEM p

Step 1) All of the unique Tax Identification Numbers (TINs) in Part B car were identified for the measurement year 2006 or 2007. The source of the database. A description of data sources used for the GEM project can be

- The unit of analysis for GEM quality measures for medical groups i included on all Part B carrier claim line items and represents indiv units providing medical services. This enables the GEM project a group practices to be completely claims data driven.
- TINs are included on Part B carrier claim line items and can also be key variables available on Part B claim line items that are needed beneficiary attribution and quality measure calculation. They incl Identification Numbers (UPINs) [National Provider Identifiers (N implemented in 2006 and 2007], provider specialty codes, benefic ICD-9 diagnosis codes and CPT codes.

Step 2) The GEM project focuses on TINs for medical groups. Therefore laboratories, medical equipment suppliers and other types of providers bil carrier claims are screened out of the GEM project database. In addition, solo practitioners are not included. For the GEM project, a medical group an organization that bills CMS for medical services to Medicare beneficia least two practitioners, at least one of whom is credentialed as a physician a result, solo practitioners are screened out and are not eligible for conside These screening processes are conducted by identifying all unique GEM-e TINs in the HAJI database by applying both of the following inclusion cri

1) Medical group TINs for GEM are defined as those that had physic

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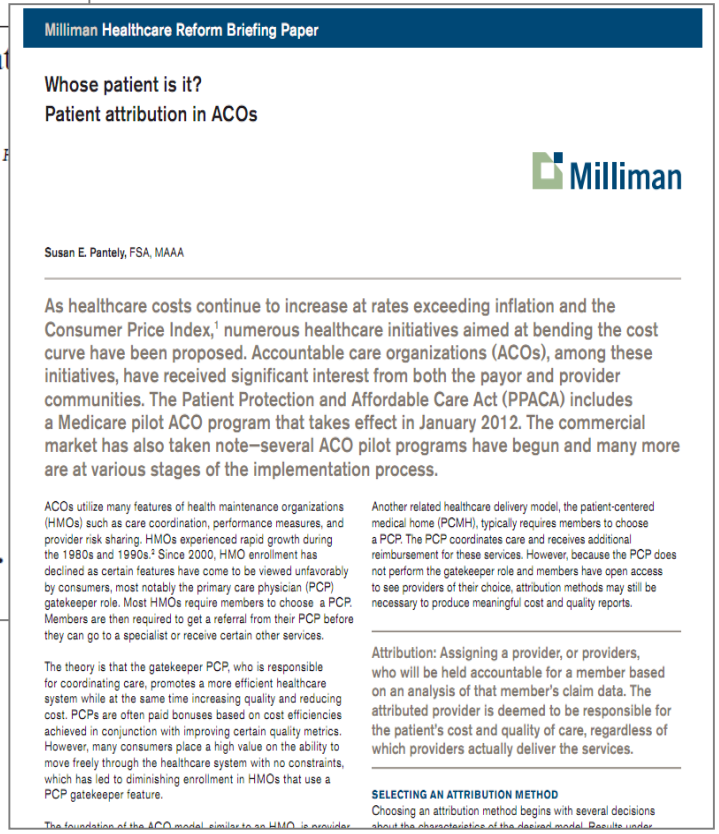
Multiple Attribution of Episodes for Physician Profiling in Medicare: A Preliminary Investigat

A study conducted by staff from Thomson Reuters H for the Medicare Payment Advisory Commission

June 2009 •



Milliman Healthcare Reform Briefing Paper

Whose patient is it?
Patient attribution in ACOs

Milliman

Susan E. Pantely, FSA, MAAA

As healthcare costs continue to increase at rates exceeding inflation and the Consumer Price Index,[1] numerous healthcare initiatives aimed at bending the cost curve have been proposed. Accountable care organizations (ACOs), among these initiatives, have received significant interest from both the payor and provider communities. The Patient Protection and Affordable Care Act (PPACA) includes a Medicare pilot ACO program that takes effect in January 2012. The commercial market has also taken note—several ACO pilot programs have begun and many more are at various stages of the implementation process.

ACOs utilize many features of health maintenance organizations (HMOs) such as care coordination, performance measures, and provider risk sharing. HMOs experienced rapid growth during the 1980s and 1990s.[2] Since 2000, HMO enrollment has declined as certain features have come to be viewed unfavorably by consumers, most notably the primary care physician (PCP) gatekeeper role. Most HMOs require members to choose a PCP. Members are then required to get a referral from their PCP before they can go to a specialist or receive certain other services.

The theory is that the gatekeeper PCP, who is responsible for coordinating care, promotes a more efficient healthcare system while at the same time increasing quality and reducing cost. PCPs are often paid bonuses based on cost efficiencies achieved in conjunction with improving certain quality metrics. However, many consumers place a high value on the ability to move freely through the healthcare system with no constraints, which has led to diminishing enrollment in HMOs that use a PCP gatekeeper feature.

Another related healthcare delivery model, the patient-centered medical home (PCMH), typically requires members to choose a PCP. The PCP coordinates care and receives additional reimbursement for these services. However, because the PCP does not perform the gatekeeper role and members have open access to see providers of their choice, attribution methods may still be necessary to produce meaningful cost and quality reports.

Attribution: Assigning a provider, or providers, who will be held accountable for a member based on an analysis of that member's claim data. The attributed provider is deemed to be responsible for the patient's cost and quality of care, regardless of which providers actually deliver the services.

SELECTING AN ATTRIBUTION METHOD

Choosing an attribution method begins with several decisions

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Current applications of patient attribution in Massachusetts

- CMS Shared Savings Program: Accountable Care Organizations
- Patient Centered Medical Home Initiative
- CHIPRA Quality Demonstration Project
- Reporting of Health Care Payment Arrangements

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APCD Analytic Workgroup – Guest Presenter

- Janice A. Singer, Director of Operations, Massachusetts Health Quality Partners

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MHQP has been focused on attribution methodologies since 2007

- CMS Better Quality Information (BQI) project
  - FFS Medicare data and Commercial PPO data
- Plan and Provider PPO Attribution Taskforce
- CMS CHIPRA Quality Demonstration Project
  - MassHealth & Commercial data from the MA Health Care Quality and Cost Council (HCQCC)
- RWJF Resource Utilization Grant
  - Collaborated with Bill Thomas, U. of S. Maine, on attributing ETGs to Providers

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CMS Better Quality Information Project

- Attributed all care to PCP with plurality of Evaluation & Management (E&M) visits in 18 months prior to the end of the measurement year
- If there was a tie, we attributed to the PCP with the most recent visit
- If NO visits with a PCP, relevant care was attributed to a specialist (e.g. endocrinologist for diabetes) if there was an E&M visit to *ONLY ONE such specialist (not a plurality)*
- *Only one physician received attribution*

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CMS Better Quality Information Project: Validation of Attribution

- We surveyed 181 physicians (51% response rate)

- Provided them a list of patients we had attributed to them and asked them if they:
  - had seen the patients in the time period
  - saw themselves as at least partially responsible for seeing these patients received preventive & chronic care management services
  - saw themselves as the patients PCP

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CMS Better Quality Information Project: Validation of Attribution (continued)

- 1,234 patients had been attributed to the MDs who responded to the survey
- MD respondents agreed that they had seen 93% of these patients
- *MDs further agreed they were either responsible for care and/or saw self as PCP for **96%** of the patients they had seen*

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CMS Better Quality Information Project: Validation of Attribution (continued)

- MDs answered “No” to at least one question for 12% of the patients.
- In the majority of these cases, they explained that the patient was being followed by someone else *in their practice*.
- This was key for MHQP, as we report at the practice or medical group level, not at the individual MD level.

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Plan and Provider PPO Attribution Taskforce

- Attribute 1st to PCPs with most recent E&M visit , not the most visits
- Attribute to PCPs with any visit if no E&M visits
- Two categories of PCPs
  - Primary Care/PCPs (P.C. specialty & are PCP for M.C plans)
  - Specialist/PCPs, (non-P.C. but serve as a PCP)
- Attribute to practice sites
  - A few groups that bill at the site level

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Plan and Provider PPO Attribution Taskforce (continued)

- If NO visits with any PCP, relevant care was attributed to a specialist (e.g. endocrinologist for diabetes) if there was any visit (not just E&M)
  - If 2 or more relevant specialists, attribute using the one with most visits (not most recent)
- If no visits at all but multiple Rx claims in past 6 mos. from a PCP, attribute care to PCP
  - IF Rx from multiple PCPs, to one with most Rx claims (if tie, most recent)

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CMS CHIPRA Quality Demonstration Project

- Similar to the PPO attribution algorithm with a few differences:
- First look for at least 2 visits, one of which was a well visit, in past 18 months
  - More than one PCP – most recent visit
  - If most recent on same date, most frequent
- Then look for 1 visit only that was a well visit
- Then PCPs with only non-well visits
- Then specialists for relevant care

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RWJF Resource Utilization Grant

- Cost Plurality ≥ 30% of professional costs in an episode
- Cost Majority ≥ 50% of professional costs
- Visit Plurality ≥ 30% of E&M visits
- Visit Majority ≥ 50% of E&M visits

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RWJF Resource Utilization Grant (continued)

- At least 95% of episodes are attributed to same physician no matter which method used
- No difference between the 2 cost methods and no difference between the 2 visit methods
- At least 90% of physicians are assigned to the same tier regardless of attribution rule used

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Basic Decisions on Methodology

- Attribute to one or many practitioners
- Costs or E&M Visits
- Majority or Plurality (and if so, is there a threshold percentage) or Majority
- Timeframe for attribution

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Q&A session

- Questions from webinar participants
- Questions emailed to DHCFP (dhcfp.apcd@state.ma.us)
- Open discussion

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APCD Analytic and Technical Workgroups

Upcoming Schedule	
APCD Technical Workgroup 4th Tuesday of each month	*December 27th meeting cancelled* Next meeting on January 24th
APCD Analytic Workgroup 3rd Tuesday of each month	January 17th

For meeting materials and information, please visit:

www.mass.gov/dhcfp/apcd

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